87 1877

No. _____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

STEVE HARTENSTINE,
Petitioner,

vs.

SUPERIOR COURT OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO, NORTH DESERT DISTRICT,
Respondent.

(BLUE CROSS OF SOUTHERN CALIFORNIA, CALIFORNIA PHYSICIANS SERVICE, d.b.a. BLUE SHIELD OF CALIFORNIA,
Real Parties in Interest.)

ON PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL FOR THE FOURTH APPELLATE DISTRICT, DIVISION TWO

PETITION FOR WRIT OF CERTIORARI

MICHAEL V. McINTIRE, ESQ.*
DIANA J. CARLONI, ESQ.
Law Offices of Michael V. McIntire
41191 Big Bear Boulevard
Post Office Box 1623
Big Bear Lake, California 92315
(714) 866-7697
Attorneys for Petitioner

*Counsel of Record

Lawyers Brief Service / Legal Publishers / (213) 383-4457 / (714) 720-1510

104pp

QUESTION PRESENTED

The sole issue presented herein is:

> Whether the Federal Employees Health Benefits Act, which does not regulate the claims practices of its carriers, preempts the California Unfair Practices Act and state common law which regulate and provide remedies for abusive insurance claims practices, so as to deprive federal employees and their dependents of the protection of the state laws which are their only recourse against such practices.

The U.S. statute involved is the Federal Employees Health Benefits Act, 5 U.S.C. §§8901, *et seq.* (hereafter FEHBA), which authorizes the federal government to enter contracts to provide federal employees with health benefits. The state laws are the California Unfair Practices Act (California Insurance Code §§790 *et seq.*) and related common law which regulate insurance company claims practices, prohibit abusive claims adjustment practices, and provide remedies to the insured who is harmed by such practices.

LIST OF PARTIES TO THIS PROCEEDING

The parties to the writ proceeding in the Court below are Steve Hartenstine, the petitioner herein; the Superior Court of the State of California for the County of San Bernardino, North Desert District; Blue Cross of Southern California (hereafter "Blue Cross"); and California Physicians Service, d.b.a. Blue Shield of Southern California (hereafter "Blue Shield"). The United States Office of Personnel Management filed an *amicus curiae* brief in opposition to the interests of petitioner, the aggrieved federal employee.

Because 28 U.S.C. §2403(b) may apply to this case, this Petition is being served on the Attorney General of the State of California.

TABLE OF CONTENTS

Page

LIST OF APPENDICES

TABLE OF AUTHORITIES

Page

Cases

Page

Federal Statutes

Page

Regulations

State Statutes

Congressional Records, Hearings and Legislative History

Page

No. _____

IN THE

Supreme Court of the United States

October Term, 1987

STEVE HARTENSTEIN,

Petitioner,

vs.

SUPERIOR COURT OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO, NORTH DESERT DISTRICT,

Respondent.

(BLUE CROSS OF SOUTHERN CALIFORNIA, CALIFORNIA PHYSICIANS SERVICE, d.b.a. BLUE SHIELD OF CALIFORNIA,

Real Parties in Interest.)

PETITION FOR WRIT OF CERTIORARI

Petitioner, Steve Hartenstine, respectfully prays that a Writ of Certiorari issue to review the decision and opinion of the California Court of Appeal for the Fourth Appellate District entered on November 16, 1987.

OPINIONS BELOW

The order of the California Superior Court for the County of San Bernardino, North Desert District, granting Motion for Summary Judgment on the federal law grounds that the FEHBA preempted California laws regulating unfair claims practices, was not reported. It is reprinted in Appendix "C" attached hereto.

The opinion of the California Court of Appeal, Fourth Appellate District, affirming the Superior Court's order granting summary judgment adverse to petitioner, is reported at 196 Cal.App.3d 206, 241 Cal.Rptr. 756 (1987), and is reprinted in Appendix "A" attached hereto.

The order of the California Supreme Court denying petitioner's Petition for Review, which was not reported, is reprinted in Appendix "B" attached hereto.

JURISDICTION

Petitioner, a federal employee, was sued by Huntington Intercommunity Hospital for unpaid hospital charges which were submitted to and rejected by respondent Blue Cross, his health benefits carrier under the FEHBA. Petitioner sued respondents Blue Cross and Blue Shield in a cross action filed on March 4, 1984.

On August 25, 1986, Blue Cross and Blue Shield filed a Motion for Summary Judgment on the grounds that the FEHBA preempted petitioner's state law tort action arising from the unlawful claims adjusting practices engaged in by Blue Cross and Blue Shield. The Superior Court granted the motion on January 12, 1987.

Thereafter, petitioner filed a timely Petition for Writ of Mandate in the California Court of Appeal. On November 16, 1987, the Court of Appeal denied the petition, holding that the FEHBA preempted all state laws regulating unfair claims practices of insurance carriers which insure federal employees under the FEHBA. Petitioner filed a timely Petition for Review in the California Supreme Court, which was denied by order filed February 18, 1988.

The jurisdiction of this Court to review the decision of the California Court of Appeal is invoked under 28 U.S.C. §1257(3).

STATUTES INVOLVED

The Federal Employees Health Benefits Act, 5 U.S.C. §§8901-8913, is reprinted in Appendix "D" attached hereto. The California Unfair Practices Act, Cal.Ins. Code §§790-790.10, is reprinted as Appendix "E".

STATEMENT OF THE CASE

Petitioner was a federal employee insured for health benefits by Blue Cross and Blue Shield under the Federal Employees Health Benefits Act. Petitioner's dependent daughter was admitted to Huntington Intercommunity Hospital in California at the insistence of her treating physician, where she received psychiatric treatment from August 28, 1980 to December 23, 1980. After petitioner's daughter was discharged, Blue Cross unilaterally decided, without contacting the treating physician, that petitioner's daughter should have been discharged from the hospital on November 15, 1980, instead of December 23, 1980. Accordingly, Blue Cross summarily notified petitioner that Blue Cross had rejected his claim for hospital expenses for

the period from November 15 to December 23, 1980, which amounted to $7,709. Blue Cross gave petitioner no prior notice, and offered petitioner no explanation, other than that it had retroactively concluded that the hospitalization after November 15 was "not medically necessary."

Thereafter the hospital sued petitioner for the $7,709 of hospital expenses which were unpaid by Blue Cross, plus interest and attorneys' fees. Petitioner filed a cross-complaint against Blue Cross, in which petitioner sought payment of the hospital expenses, plus damages in tort for Blue Cross' failure to process the claim fairly and in good faith, and for practices which were made unlawful by the California Unfair Practices Act, Cal.Ins. Code §790.03(h).[1] Blue Cross moved for summary judgment to dismiss the tort claims, upon the grounds that such claims were preempted and barred by the FEHBA. Blue Cross argued that the California laws regulating insurance company claims practices do not apply to California insurance companies which insure California citizens who are federal employees insured under the FEHBA.

The trial court granted the motion and dismissed Hartenstine's tort claims against Blue Cross, on the grounds that such claims were preempted by the FEHBA. (Appendix "C", p.4, para. 15-17).

The Court of Appeal denied Hartenstine's Petition for a Writ of Mandate, holding, in an opinion certified for publication, that California state laws which require insurance carriers to adjust claims of their insureds promptly, fairly and in good faith, cannot apply to claims submitted to California insurance companies by federal

---

[1] Under California law, the provisions of the Unfair Practices Act are enforceable by both the California Insurance Commissioner *and* by the individual insured who is injured by such practices. *Royal Globe Ins. Co. v. Superior Court*, 23 Cal.3d 880, 153 Cal.Rptr. 842 (1979).

employees who are insured pursuant to the FEHBA. (Appendix "A").

The California Supreme Court has declined to review this decision. (Appendix "B").

REASONS FOR GRANTING THE WRIT

I

SUMMARY OF REASONS FOR GRANTING THE WRIT

The issue raised herein is of vital importance to the state of California and other states, whose historic regulatory powers over insurance companies are substantially affected, and to millions of federal employees and their dependents who rely upon state laws as their only protection against unfair claims practices engaged in by their own insurance carriers.

Petitioner requests that this Court grant the writ for the following reasons:

1. The decision of the California Court of Appeal (and the Ninth Circuit decision upon which it relies) are in direct conflict with all other decisions of United States courts which have addressed the issue.

2. The legislative history and prior administrative interpretations of the FEHBA's preemption provision disclose an unambiguous legislative intent that the FEHBA *not* preempt state regulatory powers.

3. If upheld, the decision of the court below will deprive millions of federal employees and their dependents of the protection of the state statutory and common law which are the only laws in existence to control abusive claims

practices. No other class of citizens is denied this important protection.

4. The opinion below effectively deprives federal employees and their dependents of all judicial review of the claims practices of their insurance carriers.

5. The opinion below deprives the states and their Insurance Commissioners of their historic regulatory authority over the claims practices of insurance corporations doing business in their states.

II

THE DECISION BELOW AND THE NINTH CIRCUIT CASE UPON WHICH IT RELIES DIRECTLY CONFLICT WITH THE OTHER U.S. COURT DECISIONS ON THE ISSUE PRESENTED

In 1984, the Tenth Circuit Court of Appeals held that the FEHBA did not conflict with, and therefore did not preempt, Oklahoma state laws which authorized tort claims against an FEHBA carrier which refused to pay the plaintiff's claim. *Howard v. Group Hospital Service, d.b.a. Blue Cross and Blue Shield of Oklahoma,* 739 F.2d 1508 (10th Cir. 1984). In a well-reasoned decision which analyzed and rejected the same arguments which Blue Cross made in the California Court of Appeal below, the *Howard* court said:

> "Blue Cross argues that because the OPM has a procedure to review denial of benefits to plan participants [citation], permitting state courts to apply state law in the type of situation before us

> substantially conflicts with the federal regulatory scheme. We do not agree." (739 F.2d at 1511).[2]

More recently, on October 21, 1987, the U.S. District Court for the Eastern District of Wisconsin addressed the identical preemption issue, and ruled that an insured's state tort claim against his FEHB carrier was not preempted by the FEHBA. *Eidler v. Blue Cross and Blue Shield United of Wisconsin*, 671 F.Supp. 1213 (E.D. Wis. 1987). In *Eidler*, the court examined the legislative history of 5 U.S.C. §8902(m)(1) (the FEHBA's only preemption provision), and noted the absence of any factual basis for Blue Cross' *ipse dixit* argument that state tort law conflicts with the FEHBA insurance contract. The court held:

> "Defendant can point to no contractual provisions that conflict with a Wisconsin bad faith tort claim. The bare allegation that the claim will relate to the contract in question does not suffice under the standard set forth in §8902(m)(1). Therefore, summary judgment on this point is denied." (671 F.Supp. at 1217).

In 1985, a California state appellate court reached the same conclusion — the FEHBA does not preempt an insured's bad faith tort claims against the carrier. *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 589, 209 Cal.Rptr. 781, 793 (1985).

---

[2] The facts in *Howard* are strikingly similar to the facts in the instant case. In *Howard*, as in the instant case, the FEHBA carrier was Blue Cross. In *Howard*, as in the instant case, the claim was denied after Blue Cross had paid a portion of the claim. In *Howard*, as in the instant case, Blue Cross refused payment on the grounds that the remainder of the treatment was not medically necessary.

The only federal court decision which holds that state law bad faith tort claims are preempted by the FEHBA is *Hayes v. Prudential Insurance Company of America, et al.*, 819 F.2d 921 (9th Cir. 1987). In *Hayes*, the Ninth Circuit analogized the FEHBA to the entirely different Employee Retirement Income Security Act, (29 U.S.C. §§1001, *et seq.*)(ERISA), without analysis of either statute, and held that because ERISA preempts broad areas of state laws, FEHBA preempts state laws governing insurance claims practices.

The decision of the California appellate court below, blindly following *Hayes*, similarly holds that the FEHBA preempts state laws regulating claims practices. The effect is to deprive millions of federal employees[3] of the protection of the state laws which are their only recourse against predatory claims practices of their carriers.

This harshly discriminatory result is the product of flawed reasoning. Both *Hayes* and the California appellate court which followed *Hayes* "reasoned" that, (1) because prior cases have held that §8902(m)(1) of the FEHBA preempts certain state laws which conflict with specific provisions of the FEHBA contract with the carriers[4], and

---

[3] Blue Cross estimates that it provides coverage to approximately one-half million federal employees and dependents in California alone. See Petition for Review, filed in the Supreme Court of California by Blue Cross of Southern California in *Blue Cross of Southern California v. Superior Court* (Miller), Case No. Civil S000080, page 5. Blue Cross is only one of many carriers which insure federal employees under the FEHBA in every state in the union.

[4] The FEHBA cases relied upon by the court below, and by *Hayes*, involve state laws which directly conflict with express provisions of the FEHBA contract, and are therefore clearly preempted by §8902(m)(1). Those cases are not on point as to state laws regulating claims practices, which are at issue here. *Blue Cross and Blue Shield, Inc. v. Department of Banking and Finance*, 791 F.2d 1501, 1505 (1986), held that a state

(2) because ERISA preempts a broad spectrum of state laws, therefore the FEHBA preempts state laws regulating claims practices.

In addition to the obvious *non sequitur*, the court's purported analogy between FEHBA to ERISA is not well taken. ERISA is as different from the FEHBA as night is from day.

Unlike FEHBA, which is in the nature of enabling legislation, ERISA establishes detailed rights, duties, remedies, enforcement procedures and penalties. ERISA specifically requires carriers to establish standards for notifying claimants of action on their claims. (29 U.S.C. §1133.) The regulations promulgated under ERISA establish detailed, mandatory claims procedures, which are binding on the carriers. (29 C.F.R. Part 2560.) ERISA provides civil and criminal penalties for its violation (29 U.S.C. §1131, §1132(i)), and awards attorneys' fees to an insured who is forced to litigate against the carrier. (29 U.S.C. §1132(g)).

The FEHBA contains no corresponding provisions.

Because the decision below, and the recent Ninth Circuit decision in *Hayes*, are the first and only cases to hold that state regulatory laws established to protect state citizens

---

escheat statute which directly conflicted with an express provision of an FEHBA contract was preempted by §8902(m)(1); *LaBelle v. Blue Cross and Blue Shield United*, 548 F.Supp.251 (W.D. Wis. 1982), held that the FEHBA contract provisions setting time limits within which to sue for benefits preempted the state law statute of limitations. In *Myers v. United States*, 767 F.2d 1072 (4th Cir. 1985), the court held only that an insured who successfully sued the United States for a determination that his FEHBA policy covered his claim was not entitled to attorneys' fees. None of these cases, upon which the court below relies, touched the issue raised herein.

from abusive insurance practices do not protect federal employees, the issue is now ripe for review by this Court.

III

THE LEGISLATIVE HISTORY OF THE PREEMPTION CLAUSE OF THE FEHBA DISCLOSES AN UNAMBIGUOUS CONGRESSIONAL AND EXECUTIVE OFFICE INTENT TO PRESERVE THE STATES' TRADITIONAL POWERS TO REGULATE INSURANCE CARRIERS

When the issue is federal preemption of state laws, the sole determinant is legislative intent. As this Court has repeatedly emphasized, "The purpose of Congress is the ultimate touchstone." *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. __, 95 L.Ed.2d 39, 46, 107 S.Ct. 1549, 1552, (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747, 105 S.Ct. 2380, 2393 (1985); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 85 L.Ed.2d 206, 105 S.Ct. 1904, 1909 (1985).[5]

The legislative history of the FEHBA, and of §8902(m)(1), its preemption statute, discloses an unmistakable congressional intent to limit preemption only to those state laws which conflict with the specific benefits provisions contained in an FEHB contract.

---

[5] The California Court of Appeal below gave lip service to this principal, but thereafter ignored the legislative history and eschewed analysis of Congressional intent, electing instead to follow *Hayes*. In *Hayes*, the court neither mentioned nor discussed the question of legislative intent, preferring instead to rest its decision, without analysis, upon this court's decision involving ERISA, an entirely different statute than the FEHBA.

The FEHBA was enacted in 1959 to protect federal employees from unpredictable costs of medical care, and to assure that federal employee health benefits were compatible with those of their colleagues in the private sector. *American Federation of Government Employees v. Devine*, 525 F.Supp. 250, 252 (D.C.D.C.1981). When the FEHBA was first enacted, there was no preemption provision of any kind in the Act. It was not until 1978, 19 years later, that 5 U.S.C. §8902(m)(1) was added to the Act, as the Act's only preemption provision.

When §8902(m)(1) was proposed and debated, Congress and the Administration were united in the belief that the FEHBA did not preempt state laws regulating insurance carriers who were contractors under the act. In a 1975 report by the Comptroller General of the United States, the administrative interpretation of the FEHBA was stated in unequivocal terms:

> "CSC's position has been that 'the States have the authority to both regulate and tax health insurance carriers operating under the Federal Employees Health Benefits Program of Chapter 89 of Title 5 of the United States Code.' In response to the FEHB carriers' requests [for a regulation restricting the states' power to license and tax such carriers], CSC told the carriers that ¶the FEHB Act was not designed to regulate the insurance business or to override any State regulatory scheme, ¶no legal basis exists for CSC to issue a regulation restricting the applicability of State laws to FEHB contracts. . ."
>
> (Report of the Comptroller General of the United States, "Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers," October 17, 1975, at p.15).

5 U.S.C. §8902(m)(1) was intended, designed and drafted to be a very narrow, surgical response to a specific conflict which bothered federal officials. The problem was that some states were attempting to require federal government health insurance plans to include certain types of coverage (specifically, treatment by chiropractors) which the federal plans did not then include. Thus, 5 U.S.C. §8902(m)(1) was created to preempt state laws only to the extent that state laws attempted to force federal health plans to include benefits other than those chosen by the federal plan. Senate Report 95-903, p.1414; House Report No. 94-1211, pp. 2-3; House Report No. 95-282, pp. 4-5.

As the bill progressed through both houses of Congress over a period of several years, the bill's administration sponsor, the U.S. Civil Service Commission (predecessor of the Office of Personnel Management) repeatedly took pains to assure Congress that the preemption bill was not intended to infringe upon traditional state regulatory power over the insurance industry, except to the extent necessary to solve the specific problem at hand. Hearings Before House Subcommittee on Retirement and Employee Benefits, March 23, 1976, p.4; Hearings Before Senate Subcommittee on Civil Service and General Services, September 14, 1977, pp. 3,8; Senate Report No. 95-903, p.1418; House Report. No. 95-282, pp. 4-5.

The limited nature of the preemption provision of the FEHBA is underscored in Senate Report No. 95-903, at p.1415, in the following words:

> "Such a preemption, however, is purposely limited and will not provide insurance carriers under the program with exemptions from State laws and regulations governing other aspects of the insurance business. . ."

The provisions of the FEHBA provide no regulation of, or protection against, abusive claims practices engaged in by carriers which write policies under the FEHBA. Instead, the regulations promulgated under the FEHBA expressly disclaim all federal jurisdiction over disputes between the insurer and the insured regarding payment or adjusting of claims. 5 C.F.R. §890.107 provides, in pertinent part:

> "An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan."

Congress intended the FEHBA to be a *benefit* to federal employees, not a subterfuge to deprive federal employees of consumer protections accorded them under state law. In 1977, at a hearing before a Senate Subcommittee considering the bill which became §8902(m)(1), the following exchange occurred between a Senator and Thomas Tinsley, CSC spokesman for the bill:

> "Senator Sasser. Mr. Tinsley, I want to ask you several questions this morning. . . First, will the passage of this bill injure States and their citizens who are Federal employees? . . .
>
> "Mr. Tinsley. Certainly the exercise of total preemption in this area in my own judgment would have the effect of possibly injuring individuals in those States whether they be Federal employees or citizens of those States. ¶It is my personal view that the regulation of insurance should remain in the hands of the States. ¶It is certainly not our intent to interfere with that."
>
> (Hearing before the Subcommittee on Civil Service and General Services of the Committee on Governmental Affairs, U.S. Senate, Ninety-fifth Congress, Sept. 14, 1977, at page 3).

The same administration spokesman, Thomas Tinsley, had previously testified before a House Subcommittee that:

> "This particular bill that is before the committee asks for nothing more than to preempt State laws and insurance regulations insofar as they apply primarily to the benefit structure. It is not asking for complete preemption in this instance." (Hearings before the Subcommittee on Retirement and Employee Benefits of the Committee on Post Office and Civil Service, House of Representatives, Ninety Fourth Congress, March 23, 1976, at page 4.)

In the words of the U. S. District Court in *Presti v. Connecticut General Life Ins. Co., Inc.*, 605 F.Supp. 163 at 168 (N.D. Cal. 1985) (holding that ERISA does not preempt the California Unfair Practices Act):

> "The Court cannot believe that the consumer protections afforded California policy holders were meant to be withdrawn from those persons whose coverage was provided under an employee benefit plan."

The case below has skewed the FEHBA to make the act a sword which deprives federal employees of important consumer protections created by state laws regulating insurance claims practices.

The prompt intervention of this Court is needed to restore those important protections.

IV

CALIFORNIA LAWS REGULATING INSURANCE ARE THE ONLY LAWS AVAILABLE TO PROTECT FEDERAL EMPLOYEES IN CALIFORNIA FROM ABUSIVE INSURANCE COMPANY CLAIMS PRACTICES

California law extends to all California citizens a remedy against abusive claims practices. The law is applicable to all insurance carriers doing business in the state. The FEHBA contains no protection against such practices, nor are claims practices the subject of FEHBA contracts. Thus, if the FEHBA preempts these California laws as to federal employees, the federal employees have no protection at all.

In 1959, the California Legislature enacted the Unfair Practices Act, a strong and detailed set of laws regulating insurance industry claims practices in California, designed to prevent the widespread, pervasive abuses of power exercised by insurance companies when adjusting claims. (Ins. Code §§790 *et seq.*). The statute includes a lengthy list of specific types of claims practices which are expressly prohibited (Ins. Code §790.03(h)), some of which are the basis for petitioner's suit against Blue Cross and Blue Shield.

The Unfair Practices Act authorizes the California Insurance Commissioner to impose penalties and sanctions against insurance carriers which violate its provisions. (Ins. Code §§790.04 *et seq.*) Its provisions are also enforceable by an individual insured who is damaged by the carrier's violation thereof. *Royal Globe Ins. Co. v. Superior Court*, 23 Cal.3d 880, 884, 153 Cal.Rptr. 842 (1979). The Unfair Practices Act applies to all corporations, associations and persons engaged in the business of insurance in the state. (Ins. Code §790.01).

By contrast, the FEHBA does not regulate any aspect of insurance claims practices.

Neither the FEHBA, nor any regulations issued under it, nor the FEHBA contracts, deal with *the manner* in which claims are to be adjusted and paid by carriers insuring federal employees. The subject of insurance company claims practices is entirely omitted from the FEHBA.

Thus, federal employees deprived of the protection of state laws are thrust into a "no-man's-land" in which each employee is legally defenseless in dealing with an economically powerful carrier, who is unrestrained from engaging in the abusive practices which led to the creation of the state laws which Blue Cross now challenges.

V

THE DECISION BELOW DEPRIVES FEDERAL EMPLOYEES OF ALL EFFECTIVE JUDICIAL REVIEW OF THE CLAIMS PRACTICES OF FEHB CARRIERS

There are no federal statutes or regulations which require FEHB carriers to adjust claims of federal employees fairly, promptly and in good faith.

To the contrary, the regulations provide that disputes between a federal employee and the FEHB carrier are to be resolved between the carrier and the employee, and are not the business of the federal government. 5 C.F.R. §890.107.

A federal employee insured under the FEHBA who is not paid the full amount of the benefits due cannot sue the United States. 5 C.F.R. §890.107.

Furthermore, a suit by the employee against the carrier cannot be brought in the federal courts. Federal courts uniformly hold that they have no original jurisdiction to entertain such suits. *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir.1984); *Director Edward J. Meyer Memorial Hospital v. Stetz*, 433 F.Supp. 323 (W.D.N.Y. 1977).

As a result of the decision below, the federal employee now finds that the doors to the state courthouses are also closed.

If the FEHBA bars suits in state courts based on state law, as the court below has held, there is no court anywhere with jurisdiction to review the claims practices of an FEHB carrier.

The sliver of a state law remedy which remains, i.e., the "right" to sue the carrier in state court for a recovery which is limited solely to the amount of money which the carrier wrongfully withheld, is of little comfort. Unregulated by state law, FEHB carriers will be free to pressure federal employees to accept lower benefits than they are entitled to, to deny claims without fair investigation, to misrepresent claims information and to force the federal employee to pay the expenses of litigation before the carrier pays a lawful claim, all of which practices are prohibited by existing state law. A federal employee, such as petitioner, who suffers severe economic injury because his FEHB carrier refuses to pay his covered medical expenses will find little relief in the "right" to expend thousands of dollars in legal fees, money he does not have, to sue his carrier under restrictions which limit his recovery to the amount of his unpaid claim.

By depriving federal employees of remedies under state laws, where no remedy is available under federal laws, the decision of the court below would deprive federal employees, as a class, of access to all courts and of all remedies against the unlawful acts of their FEHB carriers.

VI

THE DECISION BELOW CURTAILS THE STATE'S TRADITIONAL POLICE POWER TO REGULATE INSURANCE CLAIMS ADJUSTING PRACTICES

The California Unfair Practices Act was enacted in 1959, almost 30 years ago. The legislature expressly declared in Insurance Code §790 that the Act was passed under the regulatory authority reserved to the states under the McCarran-Ferguson Act, 15 U.S.C. §§1011 *et seq.*

The decisions below are the only cases which hold that certain California insurers (FEHB carriers) insuring millions of California citizens (federal employees and dependents) are beyond the reach of California's regulatory power.

One other California appellate court has addressed the question; the decisions below conflict with it. *Fields v. Blue Shield*, 163 Cal.App.3d 570, 589, 209 Cal.Rptr. 781, 792-793 (1985).

Under the ruling below, neither the individual insured nor the State Commissioner of Insurance can require an FEHB carrier to adjust claims fairly and in good faith. There is no evidence that Congress ever intended so major an intervention into the traditional regulatory powers of the states.

CONCLUSION

Under the guise of "federal preemption", the California Court of Appeal, relying on a new Ninth Circuit case, has deprived millions of federal employees and their dependents of the consumer protections afforded them under state laws which control abusive insurance company practices.

The decisions below conflict with the unambiguous legislative history, deviate from prior administrative interpretation, violate the intent of Congress and depart from judicial precedent.

Yet their effect is extreme and discriminatory. By holding that states have no power to regulate or control abusive claims practices of FEHB carriers, the courts have deprived federal employees of all remedies for and protection against such abuses, and of access to the courts to review such practices. The FEHBA requires that aggrieved federal employees must resolve their individual claims disputes with the FEHB carrier in state court, under state laws which the court below holds to be invalid.

Petitioner respectfully prays that this petition be granted so that:

1. The conflict among the federal circuits on the preemption issue may be resolved;

2. The traditional regulatory and police powers of the States over insurance carriers' claims practices may be defined and preserved; and

3. Federal employees and their dependents will be entitled to the same protection from and remedies for abusive claims practices of their FEHB carriers as are their fellow citizens who are not federal employees.

Dated: May 12, 1988

Respectfully submitted,

Law Offices of
MICHAEL V. McINTIRE

By: MICHAEL V. McINTIRE, ESQ.
DIANA J. CARLONI, ESQ.

Attorneys for Petitioner

APPENDIX A

HARTENSTINE v. SUPERIOR COURT

Cite as 241 Cal.Rptr 756 (Cal.App.4 Dist 1987)

Steve HARTENSTINE, Petitioner,

v.

SUPERIOR COURT of the State of California, for the County of San Bernardino, North Desert District, Respondent.

BLUE CROSS OF SOUTHERN CALIFORNIA, et al., Real Parties in Interest.

No. E003956.

Court of Appeal, Fourth District, Division 2.

Nov. 16, 1987.

OPINION

McDANIEL, Associate Justice.

Huntington Intercommunity Hospital (Hospital) sued Stephen Hartenstine (Hartenstine), a federal employee, for $7,709.35 in unpaid hospital expenses. Hartenstine filed a cross-complaint against his insurance carriers, alleging counts in contract and in tort. The trial court granted the carriers' motion for summary adjudication of the tort counts, on the ground that those counts were preempted by the Federal Employee Health Benefits Act (5 U.S.C. § 8901 et seq., hereafter referred to as FEHBA). Hartenstine petitioned this court for a writ of mandate which would direct the trial court to vacate its order granting the motion for summary adjudication, and to enter an order denying the motion. We authorized issuance of an alternative writ, the matter is now before us for disposition and we shall deny the petition.

FACTS AND PROCEEDINGS

On August 18, 1980, Hartenstine's minor daughter Pamela was admitted to Hospital for psychiatric treatment. She was released from Hospital over four months later on December 23, 1980. At the time of her admission, she was covered as a family member under a FEHBA Service Benefit Plan in which her father was enrolled (the

Plan). The Plan was administered by Blue Cross of California and Blue Shield of California pursuant to an FEHBA-authorized contract between them and the Office of Personnel Management (OPM). The Plan recited that benefits would not be provided for hospital admissions or portions thereof which, in the judgment of the carriers, had not been medically necessary. The Plan also recited that a denial of a claim would be reconsidered by the local Blue Cross and Blue Shield upon receipt of a written request within one year of the denial, and, within 90 days after an affirmation of the denial, that the claimant could ask OPM to determine if the denial had complied with the provisions of the Plan's brochure.

In the case here, Blue Cross paid for Pamela's hospitalization from August 18, 1980, through November 14, 1980, and refused to pay for her hospitalization from November 15, 1980, through December 23, 1980, a total of $7,709.35, on the ground that its review of her records had indicated that the hospitalization after November 14 had not been medically necessary.

Hospital filed suit against Hartenstine for payment of the $7,709.35, plus interest and attorney's fees. Without, it appears, going through the Plan's review procedures, *supra*, Hartenstine filed a cross-complaint against Blue Cross and Blue Shield (the carriers) for breach of contract, breach of the covenant of good faith and fair dealing, and violation of Insurance Code section 790.03, subdivision (h) (unfair claims settlement practices). Under these theories, Hartenstine sought both compensatory and punitive (exemplary) damages.

In his first cause of action for breach of contract, Hartenstine alleged that he was a federal employee and, as such, a beneficiary of the Plan; that the Plan provided for payment of all of Pamela's hospital expenses, and that the carriers' refusal to pay her hospital expenses from November 15 through December 23, 1980, constituted a breach of contract. Hartenstine did not attach a copy of the Plan, or any other contract, to his second amended cross-complaint (the pleading as to which the summary judgment was granted.)[1]

In his second and third causes of action for breach of the covenant of good faith and fair dealing and violation of Insurance Code section 790.03, subdivision (h), respectively, Hartenstine alleged that the carriers had breached the foregoing covenant and violated the provisions of section 790.03, subdivision (h) by: (a) denying policy benefits to Hartenstine with the knowledge that the denial was contrary to established law and the terms of the policy; (b) refusing to make an adequate or good-faith investigation of Hartenstine's claim before withholding the benefits; (c) terminating payments during Pamela's hospitalization without notice or warning to Hartenstine; (d) failing to provide Hartenstine with any reasonable or justifiable basis for the denial of his claim, or with the factual or legal basis for the denial, and (e) consciously applying the

1. The only cross-complaint cited to in Hartenstine's writ petition is the *first* amended cross-complaint. We have augmented the record to include the second amended cross-complaint, and shall base our analysis on that pleading.

policy provisions so as to save money for the carriers and deprive Hartenstine of the benefits rightfully due him.

The carriers each filed an answer to Hartenstine's second amended cross-complaint. Each of the answers alleged many affirmative defenses, but neither answer alleged, as an affirmative defense, that any of the causes of action in Hartenstine's cross-complaint were preempted by federal law.

About two years later, Blue Cross noticed a motion for summary adjudication of issues without substantial controversy. In its motion Blue Cross argued, among other things, that Hartenstine's second cause of action (for breach of the covenant of good faith and fair dealing), his third cause of action (for violation of Insurance Code section 790.03, subdivision (h)), and his requests for damages for emotional distress and for exemplary damages were all preempted by federal law, and that hence Blue Cross was entitled to summary adjudication thereof.

In support of its motion for summary adjudication, Blue Cross attached the declaration of Nora Drain, a consultant in its Federal Employee Program. A copy of the Plan's 1980 Brochure (i.e., the brochure which would have applied to Pamela's hospitalization, hereafter the Brochure) was attached to the declaration. The declaration recited that it was based upon Drain's personal knowledge and that she could competently testify that:

2. At all relevant times Hartenstine was a member of the Plan.

"3. Each year, pursuant to [FEHBA, OPM] publishes, prints and distributes to all federal employees brochures regarding each Federal Employee Health Plan. The brochures are statements of benefits, exclusions and limitations for each Plan.

"4. The [Plan's brochure] is sent to all federal employees.... The provisions of the [Plan] are specifically negotiated each year between Blue Cross and Blue Shield Association and OPM. The OPM must give its approval pursuant to [FEHBA]. Upon approval of the Plan, OPM orders publication of the brochures ... OPM then distributes the brochures to the Plan's subscribers. The Brochure is part of the contract between OPM and Blue Cross and Blue Shield Association."

Blue Cross' motion, in compliance with the applicable statute, also included a statement of undisputed material facts. Facts number 4, 5 and 6 reiterated paragraphs 3 and 4 of the Drain declaration, *supra*, and cited the declaration as the evidentiary source therefor. Fact number 14 recited that Hartenstine had asserted that Blue Cross' retrospective review of his claims for Pamela's hospitalization was per se bad faith, and cited, as the evidentiary source therefor, Hartenstine's notice of motion to vacate an order submitting the case to arbitration. In that motion, Hartenstine had argued that the case should be continued until the California Supreme Court decided *Sarchett v. Blue Shield* (1984) 158 Cal. App.3d 218, 204 Cal.Rptr. 534, because, as Hartenstine argued, *Sarchett* was "almost identical on its facts" with this case, and

the California Supreme Court had granted a hearing in *Sarchett* on the issue of whether an insurer's retrospective denial of benefits was bad faith as a matter of law.

Blue Shield joined in Blue Cross' motion.

Plaintiff filed an opposition to the motion, contending that it should not be granted because: (1) the carriers had waived the defense of preemption because they had not pleaded it as an affirmative defense; (2) the State of California was an indispensable party to an adjudication of the preemption issue; (3) the Plan's brochure could not be admitted into evidence on the basis of Nora Drain's declaration, and therefore there was no competent evidence upon which to grant the motion; (4) California statutory and common law regulating the insurance industry were not preempted by FEHBA, and (5) additional evidence essential to Hartenstine's opposition to the motion existed but was not yet available to him.

In further support of his opposition to the motion, Hartenstine filed a separate statement of disputed facts, and a declaration of his attorney. In his statement of disputed facts, Hartenstine disputed Blue Cross' statements, *supra*, as to OPM's brochures in general, and the Plan's brochure in particular, on the grounds that there was no admissible evidence to support such "factual" allegations. In his declaration, Hartenstine's attorney stated that he was unable to prepare effective opposition to the motion without examining, among other things: all of the contracts between the federal government and Blue Cross "over

the years," including the contract applicable to plaintiff's claims; all documentation relative to the negotiations for such contracts; the procedures used by Blue Cross in adjusting claims for federal employees and nonfederal employees, and the federal rules and regulations relating to federal employee plans.

After a hearing, an order was entered granting the carriers' motion for summary adjudication which recited in relevant part:

"5. The Blue Cross and Blue Shield Federal Employee Service Benefit Plan brochure ... is sent to all federal employees. The ... brochure applicable to calendar year 1980 is attached as Exhibit "A" to the declaration of Nora Drain.

"6. The provisions of the federal employee plan of Blue Cross & Blue Shield are specifically negotiated between Blue Cross and Blue Shield and OPM ... Upon approval of the plan, OPM orders publication of the brochures.... OPM then distributes the brochures to the plan's subscribers. *The [Blue Cross and Blue Shield] brochure is part of the contract between OPM and Blue Cross....*

"14. In addition to the specific allegations of this complaint, Hartenstine has asserted that Blue Cross' retrospective review of claims for Pamela Hartenstine's hospitalization are per se badfaith [sic].

"15. The court finds that the provisions of 5 U.S.C. § 8902(m)(1)[2] apply to and preempt cross-complainant's second and third causes of action in their entirety. Specifically, the court finds that the retrospective review complain[ed] of is a matter relating to the 'nature and extent of coverage or benefits, including payments with respect to benefits' contemplated by the statute. Further, the court finds that the federal employees health benefits act so comprehensively provides for the nature and extent of coverage and for payment dispute resolution that application of the alleged state causes of action is inconsistent with the provisions of the act.

"16. The court finds that the emotional distress tort relief in the first cause of action of Hartenstine's cross-complaint is, likewise, not provided for by the federal employees health benefits act and is preempted.

"17. The court finds that punitive damages are neither provided for nor allowed under the federal employees health benefits act and are thus preempted." (Emphasis added.)

This petition followed.

2. 5 U.S.C. section 8902, subdivision (m)(1) recites: "The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions."

DISCUSSION

Hartenstine contends: (1) summary adjudication cannot be granted on a defense of preemption which was not raised as an affirmative defense; (2) there was no competent evidence to support the summary adjudication; (3) the carriers are collaterally estopped from asserting the defense of preemption; (4) California laws regulating insurance claims practices are not preempted by the FEHBA; (5) the trial court erred in granting the carriers' motion without giving Hartenstine an opportunity to obtain evidence in opposition, and (6) the State of California is a necessary party to a suit challenging the validity of Insurance Code section 790.03(h).

I

DEFENDANTS' FAILURE TO RAISE PREEMPTION AS AN AFFIRMATIVE DEFENSE

[1] Hartenstine contends that preemption is an affirmative defense which is waived if it is not pleaded in the answer. Not so. As the California Supreme Court stated recently in *DeTomaso v. Pan American World Airways, Inc.* (1987) 43 Cal.3d 517, 235 Cal.Rptr. 292, 733 P.2d 614: "The RLA [Railway Labor Act] preemption issue was first raised in Pan Am's trial brief. DeTomaso claims [because] the issue was not specifically pleaded as an affirmative defense, [that] it was waived. Whether or not tort claims are preempted by RLA is a question of subject matter jurisdiction (*Beers v. Southern Pacific Transp. Co.* (9th Cir.1983) 703 F.2d 425, 429) which cannot be waived. (*Summers v. Superior*

Court (1959) 53 Cal.2d 295, 298 [1 Cal.Rptr. 324, 347 P.2d 668].)" (*Id.*, at p. 520, fn. 1, 235 Cal.Rptr. 292, 733 P.2d 614.)

II

THE EVIDENCE IN SUPPORT OF THE MOTION

[2] On this point, Hartenstine contends first that the statements in Drain's declaration, *supra*, about the Plan were inadmissible to prove the facts therein, because there was no showing that Drain had personal knowledge of such facts, or that she was competent to offer legal opinions thereon. However, whether or not Drain was competent to testify to her statements about the Plan is irrelevant, because the substance of the statements is included in the FEHBA,[3] and in the Brochure which

3. 5 U.S.C., section 8902 recites, in relevant part: "(a) The Office of Personnel Management may contract with qualified carriers offering plans ... Each contract shall be for a uniform term of at least 1 year ... (d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable ... (e) ... Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned."

5 U.S.C. section 8907 recites: "(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an

was attached to Drain's declaration.[4]

In his traverse, without referring specifically to the Brochure, Hartenstine argues that the contract which was in effect when Blue Cross denied his benefits was never introduced into evidence or seen by the trial court, and was "pivotal to Blue Cross' defense of preemption." However, the Brochure, which, according to the recitations in footnote 4, *supra*, was the contract in effect when Hartenstine was purportedly entitled to his benefits (although not necessarily when Blue Cross denied the benefits), *was* introduced into evidence by

informed choice among the types of plans described by sections 8903 and 8903a of this title.

"(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—

"(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

"(2) procedure for obtaining benefits; and

"(3) principal provisions of the plan affecting the enrollee and any eligible family members."

4. The Brochure is entitled: "SERVICE BENEFIT PLAN 1980 As Revised January 1, 1980," and recites, on page 2 thereof: "Blue Cross Association on behalf of Blue Cross Plans, and Blue Shield Association on behalf of Blue Shield Plans, have entered into Contract No. CS 1039 with the Office of Personnel Management pursuant to which Blue Cross Plans and Blue Shield Plans agree to provide the Government-wide Service Benefit Plan authorized by the Federal Employees Health Benefits Law.

"This brochure is incorporated into Contract No. CS 1039 as the contract statement of benefits, exclusions, limitations and maximums...." (Emphasis added.)

way of Drain's declaration, and was specifically referred to by the trial court in its order granting the summary adjudication. Moreover, if, as Hartenstine argues, the contract was "pivotal" to Blue Cross' defense, then it was even more pivotal to Hartenstine's cross-complaint, and we cannot perceive why Hartenstine did not attach it to the complaint, or, having failed to do so, how he can credibly object to the carriers' attempt to introduce it into evidence by way of Drain's declaration.

At oral argument, Hartenstine argued that there was no reference in the Brochure to any statutory contract between the federal government and Blue Cross and Blue Shield. Not so. As noted: (1) the Brochure recites that it is part of Contract No. CS 1039 between OPM and Blue Cross Association and Blue Shield Association (see fn. 4, *supra*); (2) Paragraph 6 of the trial court's order granting summary adjudication for the carriers recites that the Brochure "is part of the contract between OPM and Blue Cross"; and (3) the contract alleged in Paragraph 4 of Hartenstine's cross-complaint is the federal employee "Service Benefit Plan pursuant to which cross-defendants [Blue Cross and Blue Shield] were to provide medical and hospitalization benefits to [Hartenstine and Hartenstine's] dependents," and the Brochure is entitled "SERVICE BENEFIT PLAN ... Administered by The Blue Cross [trademark omitted] and Blue Shield [trademark omitted] Federal Employee Program." In view of all the above, the statement of Hartenstine's attorney at oral argument

that "the trial judge here interpreted a contract without ever seeing it" is not supported by the record.

Hartenstine also contends that the carriers falsely stated, as their undisputed fact number 14, *supra*, that Hartenstine had asserted that Blue Cross' retrospective review of his claim was *per se* bad faith, and that the trial court "thereupon [i.e., on the basis of that statement] had concluded that state law was pre-empted." We need not address this issue, however, because, as we shall discuss more fully below, Hartenstine's second and third counts would have been preempted whether or not he had alleged or otherwise asserted that the carriers' retrospective review (i.e., the *manner* in which they had denied his benefits) was bad faith per se or bad faith under the circumstances of his case. In other words, what was preempted was Hartenstine's *general* claim that he was entitled to damages because the denial of his benefits had been in bad faith and unfair, and not any *specific* theory as to why the denial had been in bad faith or unfair.

Hartenstine also contends that none of the facts alleged in his cross-complaint were relevant to the preemption issue. Not so. In the cross-complaint Hartenstine alleged that: (1) at all times mentioned he was a *federal* employee; (2) as a *federal* employee he was a beneficiary of the carriers' *federal* benefit plan pursuant to *Federal* Employees Group Certificate No. R11–45–8457; (3) the carriers refused to pay him some of the benefits to which they knew he was entitled under the *federal*

plan; (4) such refusal constituted bad faith under *California* law, and a violation of *California* Insurance Code section 790.03, subdivision (h). Allegations 1, 2 and 3, which were also recited in the carriers' statement of undisputed facts, not only were relevant to the preemption issue, but also were sufficient to determine its application in the case here.

In view of all the above, Hartenstine's contention that there was no competent evidence to support the summary judgment is without merit.

III

COLLATERAL ESTOPPEL

[3] Hartenstine contends that the carriers are estopped from raising the preemption issue because Blue Shield had raised and lost the same issue in *Fields v. Blue Shield of California* (1985) 163 Cal.App.3d 570, 209 Cal.Rptr. 781. Not so. The only preemption issue which was decided in *Fields* was whether Fields' contract claim for compensatory damages for benefits under the policy was preempted. In the case here, however, the carriers do not contend that Hartenstine's claim for such benefits, in his first cause of action, is preempted. Moreover, although in *Fields* the plaintiff had also sought exemplary damages for breach of the insurer's duty of good faith and fair dealing, the jury had returned a verdict against him on that count, and the verdict had been affirmed on appeal. Accordingly, the appellate court had not addressed the issue of whether Fields' bad faith claim was preempted.

In sum, the preemption issue which was decided in *Fields* was not raised here, and the preemption issue which was raised here was not decided in *Fields*. Accordingly, Hartenstine's collateral estoppel contention is without merit, if not specious.

IV

PREEMPTION

[4] "[T]he question of whether a certain state action is pre-empted by federal law is one of congressional intent." (*Allis-Chalmers Corp. v. Lueck* (1985) 471 U.S. 202, 105 S.Ct. 1904, 1910, 85 L.Ed.2d 206.) In the case here, as noted, FEHBA contains an express preemption clause, which recites:

"The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions." (5 U.S.C. § 8902, subd. (m)(1).) "The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R.Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977)." (*Hayes v. Prudential Ins. Co. of America* (9th Cir.1987) 819 F.2d 921, 925.)

The preemptive effect of section 8902(m)(1) has been analyzed in several recent circuit court cases. In *Blue Cross &*

Blue Shield v. Dept. of Banking (11th Cir.1986) 791 F.2d 1501, the court held that Florida's Unclaimed Property Act was preempted pursuant to section 8902(m)(1) because it " 'relate[d] to' " a FEHBA plan, by having " 'a connection with or reference to such a plan.' " (*Id.*, at p. 1504.) In *Myers v. United States* (4th Cir.1985) 767 F.2d 1072, the court held that South Carolina's law allowing a plaintiff to recover attorney's fees in a successful bad faith suit against an insurer was preempted pursuant to section 8902(m)(1) because it "purport[ed] to allow recovery of additional benefits not contemplated by [the] federal insurance contract [and thus] must be deemed inconsistent [with it]." (*Id.*, at p. 1074.)

Of particular significance to the case here is the Ninth Circuit's recent decision in *Hayes v. Prudential Ins. Co. of America, supra*, 819 F.2d 921, a suit for damages in contract and tort by a beneficiary of an FEHBA plan. Relying on *Blue Cross, Meyers*, and two recent U.S. Supreme Court cases, the *Hayes* court held that the state law causes of action, including breach of a duty of good faith and fair dealing and breach of California Insurance Code section 790.03, were preempted by the FEHBA, and that the district court had properly granted summary judgment in favor of the carriers. The court's reasoning, which is precisely applicable to the case here, recites:

"Appellant contends that his state law claims [fn. omitted] are not preempted un-

der section 8902(m)(1), because the claims relate to the manner in which Postmasters and Prudential *processed* his benefits, and not to the 'nature or extent of coverage or benefits.' No such distinction can be made. *Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213–20, 105 S.Ct. 1904, 1912–16, 85 L.Ed.2d 206 (1985) (state tort claim stemming from manner in which a Labor Management Relations Act insurance benefit claim was handled is not independent of insurance contract and therefore is preempted by federal law). Moreover, the claims 'relate to' the plan under section 8902(m)(1) as long as they have a connection with or refer to the plan. *Blue Cross*, 791 F.2d at 1504. All appellants' state law claims refer to the plan, and therefore fall under the preemption clause.

"Because the state law claims invariably expand appellees' obligations under the terms of the Plan, the claims are inconsistent with the Plan and, hence, preempted under § 8902(m)(1). Our holding is supported by the Supreme Court's recent decision that the Employee Retirement Income Security Act (ERISA) preempts state common law tort and contract claims for benefits under an ERISA-regulated plan. *Pilot Life Ins. Co. v. Dedeaux*, — U.S. ——, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). ERISA's preemption clause is similar to section 8902(m)(1) of the FEHBA. [Fn. omitted.] And the Court held that the state claims

were preempted despite a saving clause, 29 U.S.C. § 1144(b)(2)(A), which has no counterpart in the FEHBA. Thus, we hold Hayes' state law claims are preempted by the FEHBA." (*Id.*, at p. 936.) (Emphasis on "processed" in original; other emphasis added.)

Hartenstine relies on the earlier circuit court case of *Howard v. Group Hosp. Service* (10th Cir.1984) 739 F.2d 1508, where the court held that a suit in an Oklahoma state court for damages in contract and tort resulting from Blue Cross' failure to pay claims under an FEHBA plan should not have been removed to the United States District Court on the basis of federal question jurisdiction (28 U.S.C. § 1441(b)). However, the analysis in *Howard* was limited to the contract claim; there was no reference to preemption in the majority opinion, and, as the concurring opinion stated, the existence of a federal preemption defense would be insufficient to invoke the exercise of removal jurisdiction.[5] Accordingly, the holding in *Howard* is irrelevant to the preemption issue in the case here.

5. On the preemption issue, the concurring opinion recited, in relevant part: "The case at bar is an action to enforce a contract. Thus the action is one that arises under state, rather than federal, law. Blue Cross in essence seeks to raise a federal preemption defense by claiming that federal law rather than state law controls the interpretation of the underlying contract. The alleged federal question does not appear on the face of the plaintiff's well-pleaded complaint. Therefore, we have no jurisdiction to adjudicate this state law cause of action on the basis of the

Moreover, the holding in *Howard* on the jurisdiction issue was not followed in *Hayes*, where the state court action was removed to the federal district court, *Myers*, where the action was brought and decided in the federal district court pursuant to 5 U.S.C. section 8912,[6] or *Blue Cross*, where the action was also brought and decided in the federal district court.[7]

Further, if we were to apply the reasoning in *Howard* on the jurisdiction issue to Hartenstine's tort claims in the case here, the result would be contrary to section 8902(m)(1)'s purpose, *supra*, of promoting uniformity in the administration of FEHBA's benefits. More specifically, the *Howard* court reasoned that "[t]he Oklahoma

alleged federal defense. [¶] ['']The well-pleaded complaint rule was framed to deal with precisely such a situation.... [S]ince 1887 it has been settled law that a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case.['] [Citations.]" (*Id.*, at p. 1513.)

6. Section 8912 recites: "The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court, of a civil action or claim against the United States founded on this chapter."

7. In view of the above, Hartenstine's statement on page 11 of his traverse that "the doors of the federal courts are closed to an insured federal employee seeking to recover benefits under an insurance plan established under the authority of the Health Benefits Act" is not an accurate statement of existing law.

Blue Cross contract at issue here is a federal contract authorized by federal law and negotiated by OPM, but the rights created under the contract belong to the participants. Essentially, denial of an individual claim because the carrier claimed that a treatment was not a 'medical necessity' is a private controversy in which the federal government simply does not have an interest sufficient to justify invoking federal question jurisdiction." (*Howard v. Group Hosp. Service, supra*, 739 F.2d 1508.) Such reasoning not only is contrary to the uniformity purpose of section 8902(m)(1), *supra*, but also disregards the jurisdictional provisions of section 8912 (see fn. 6, *supra*). We therefore decline to apply the reasoning to the case here.

[5] Hartenstine also relies on portions of the McCarran–Ferguson Act (15 U.S.C., § 1011 et seq.) for the proposition that Congress has given the states the power to regulate all matters concerning the relationship between the insurer and the insured, including policy interpretation and enforcement. Not so. Hartenstine relies on the following portions of sections 1011 and 1012:

"Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest,...." (§ 1011) "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." (§ 1012, subd. (a).)

However, the foregoing portion of section 1011 is followed by the words "and

that *silence on the part of the Congress* shall not be construed to impose any barrier to the regulation or taxation of such business by the several States" (emphasis added), and subdivision (a) of section 1012, *supra*, is followed by subdivision (b) of that section, which recites, in relevant part:

"No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, *unless such Act specifically relates to the business of insurance* ..." (Emphasis added.)

In sum, the foregoing portions of the McCarran–Ferguson Act which Hartenstine did not cite, show that his contention that that act empowers the states to regulate the insurance industry is without merit.

Hartenstine also relies on the following language in *Metropolitan Life Ins. Co. v. Mass.* (1985) 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728: "laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance [and therefore] would not be preempted by § 514(a) [the ERISA preemption statute]." (*Id.*, 105 S.Ct. at p. 2390.) However, in the next sentence, the Court described such laws as laws "wholly unrelated to plans." (*Id.*) In other words, not all state laws regulating an insurer are unrelated to benefit plans, as Hartenstine argues, but only those state laws which regulate "only" the insurer in areas which

are unrelated to benefit plans. In the case here, of course, the state laws at issue in Hartenstine's tort claims regulate the insurer in areas which *are* related to benefit plans. Accordingly, Hartenstine's reliance on the foregoing language in *Metropolitan Life* is misplaced.

Otherwise, Hartenstine contends that California laws prohibiting unfair claims practices are not preempted because they do not conflict with any of the provisions of the Plan or the FEHBA. Not so. Nowhere does the Plan or the FEHBA authorize a plaintiff to recover tort or punitive damages for the carrier's refusal to pay a claim, and "a state law which purports to allow recovery of additional benefits not contemplated by a federal insurance contract must be deemed inconsistent." (*Myers v. United States, supra*, 767 F.2d 1072, 1074.)

Moreover, in its *amicus* brief OPM argues that Hartenstine's state law claims should be preempted pursuant to section 8902(m)(1) because they are inconsistent with the Plan, and because the imposition of varying state law requirements would undermine the purposes and objectives of the FEHBA. The interpretation of a statute by an agency which is charged with its administration should be shown "great deference" by the courts, provided that the interpretation is a reasonable one. (*Udall v. Tallman* (1965) 380 U.S. 1, 85 S.Ct. 792,

801, 13 L.Ed.2d 616.)[8]

In view of all the above, we find that OPM's interpretation is reasonable, and that the trial court's ruling that Hartenstine's second and third causes of action were preempted was conclusively compelled by applicable authorities.

V

EVIDENCE IN OPPOSITION

[6] Code of Civil Procedure section 437c, subdivision (h) recites in relevant part: "If it appears from the affidavits submitted in opposition to a motion for ... summary adjudication ... that *facts essential to justify opposition* may exist but *cannot, for reasons stated, then be presented*, the court shall deny the motion, or order a continuance to permit affidavits to be obtained or discovery to be had or may make any other order as may be just." (Emphasis added.)

In the case here, Hartenstine contends that the trial court should have continued the matter to allow him to obtain: (1) the contract which applied to his complaint; (2) contracts "for prior years"; and (3) the carriers' documentation, or lack thereof, of conflicts between the rights of federal employee insureds and the rights of nonfederal employee insureds. We do not agree.

8. In his traverse, Hartenstine argues that OPM's *amicus* brief is not entitled to any deference, because, among other things, it was "conceived in secrecy [and] circulated to virtually no one other than lawyers and judges."

As to the contract, we repeat yet again that the contract *was* before the court, through the efforts of the carriers, and that we are at a loss to understand how Hartenstine can credibly argue that the court should continue the case to allow him to obtain a contract which he should have attached to his complaint over two years earlier.

As to the rest of the foregoing evidence, Hartenstine did not show, in his opposition papers, either that the evidence was "essential to justify opposition," or that he could not have obtained it in the period of over two years between the filing of his second amended complaint and the filing of Blue Cross' motion for summary adjudication. Accordingly, his contention the trial court should have continued the matter in order to allow him to obtain such evidence is without merit.

VI

THE STATE OF CALIFORNIA AS A NECESSARY PARTY

[7] Without citing any authority, Hartenstine contends that the State of California's interest in enforcing its laws requires that it be a party to this action, because Code of Civil Procedure section 389, subdivision (a) prohibits the determination of an issue in which a non-party "has" an interest. Not so.

Section 389, subdivision (a) recites that a person "shall be joined as a party in the action if . . . (2) he *claims* an interest relat-

ing to the subject of the action ..." (Emphasis added.) No such claim has been made by California in the case here, nor may Hartenstine make such a claim on California's behalf. (Significantly, although Hartenstine now argues that California is a necessary party, he did not think it was necessary to name it as a party in his cross-complaint.) Moreover, " '[t]he relative importance to the State of its own law is not material when there is a conflict with a valid federal law, for the Framers of our Constitution provided that the federal law must prevail.' " (*Fidelity Federal Sav. & Loan Ass'n. v. De la Cuesta* (1982) 458 U.S. 141, 102 S.Ct. 3014, 3022, 73 L.Ed.2d 664.)

In view of the foregoing, Hartenstine's contention that California is a necessary party is likewise without merit.

DISPOSITION

The petition is denied and the alternative writ is discharged. The petition here was not improvidently granted; it was granted "because of the significant public importance of the issues involved." (*County of Madera v. Superior Court* (1974) 39 Cal. App.3d 665, 114 Cal.Rptr. 283.) Real parties shall be entitled to their costs as provided by section 1027 of the Code of Civil Procedure.

CAMPBELL, P.J., and SCHULTE, J.*, concur.

APPENDIX B

ORDER DENYING REVIEW
AFTER JUDGEMENT BY
THE COURT OF APPEAL
4th District, Division 2, No. E003956
S003582

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

IN BANK

STEVE HARTENSTINE,

Petitioner,

vs.

SUPERIOR COURT OF THE
COUNTY OF SAN BERNARDINO,

Respondent;

BLUE CROSS OF SOUTHERN CALIFORNIA,

Real Party in Interest.

Petition for review DENIED.

Mosk, J. and Broussard, J., are of the opinion the petition should be granted.

LUCAS
Chief Justice

APPENDIX C

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO NORTH DESERT DISTRICT

HUNTINGTON INTERCOMMUNITY HOSPITAL, et al.,
Plaintiffs,

vs.

STEVEN HARTENSTINE,
Defendant.

STEVEN HARTENSTINE,
Cross-Complainant,

vs.

BLUE CROSS OF SOUTHERN CALIFORNIA, et al.,
Cross-Defendants.

NO. BCV-512 ORDER GRANTING MOTION FOR SUMMARY ADJUDICATION OF ISSUES BY CROSS-DEFENDANTS, BLUE CROSS OF CALIFORNIA AND BLUE SHIELD OF CALIFORNIA

The motion of cross-defendant, BLUE CROSS OF CALIFORNIA, pursuant to §437c of the California Code of Civil Procedure for Summary Adjudication of Issues on cross-complainant Steven Hartenstine's cross-complaint against Blue Cross of California (hereinafter referred to as "Blue Cross") and Blue Shield of California (hereinafter referred to as "Blue Shield") came on for hearing before this

court on November 3, 1986. Cross-Defendant California Physicians' Service, dba Blue Shield of California (Blue Shield) joined in the motion by Blue Cross. Blue Cross was represented by Richard W. Baine of Munger, Tolles, and Olson. Blue Shield was represented by Delbert C. Gee of Hassard, Bonnington, Rogers & Huber. Steven Hartenstine was represented by Michael V. McIntire.

Having considered the oral and written arguments, declarations and authorities, the court orders as follows:

1. Cross-Defendant Blue Cross of California, sued herein as Blue Cross of Southern California, is a corporation duly organized and existing under the laws of the State of California. Cross-Defendant California Physicians' Service dba Blue Shield of California, is a corporation duly organized and existing under the laws of the State of California.

2. At all relevant times, Steven Hartenstine (hereinafter referred to as "Hartenstine") was an employee of the federal government and a beneficiary of the Government-Wide Service Benefit Plan.

3. Hartenstine, at all relevant times, was a member of the Service Benefit Plan sponsored by Blue Cross and Blue Shield Association of which Blue Cross and Blue Shield are members.

4. Each year pursuant to the Federal Employees Health Benefits Act of 1959 as amended, the Federal Office of Personnel Management (hereinafter referred to as "OPM") publishes, prints and distributes to all federal employees brochures regarding each federal employee health benefits plan. The brochures are statements of benefits, exclusions and limitations for each plan.

5. The Blue Cross and Blue Shield Federal Employee Service Benefit Plan brochure (hereinafter referred to as "FEP Brochure") is sent to all federal employees. The FEP

brochure applicable to calendar year 1980 is attached as Exhibit "A" to the declaration of Nora Drain.

6. The provisions of the federal employee plan of Blue Cross and Blue Shield are specifically negotiated between Blue Cross and Blue Shield and OPM prior to the plan's going into effect. OPM must give its approval pursuant to the federal employees health benefit act of 1959, as amended. Upon approval of the plan, OPM orders publication of the brochures by the government printing office. OPM then distributes the brochures to the plan's subscribers. The FEP brochure is part of the contract between OPM and Blue Cross.

7. Pamela Hartenstine was admitted to the Huntington Intercommunity Hospital on or about August 18, 1980.

8. Pamela was released from the Huntington Intercommunity Hospital on December 23, 1980.

9. Blue Cross paid for Pamela Hartenstine's hospitalization from August 18, 1980 through and including November 14, 1980.

10. On December 30, 1981, Blue Cross wrote to Hartenstine and informed him that his review of Pamela Hartenstine's medical records had indicated that Pamela Hartenstine's hospitalization after November 14, 1980 was not medically necessary.

11. Blue Cross declined to pay $7,709.35 to the Huntington Intercommunity Hospital for Pamela Hartenstine's hospitalization.

12. Huntington Intercommunity Hospital filed an action against Hartenstine to collect monies allegedly owed to it.

13. Hartenstine subsequently filed the instant second amended cross-complaint against Blue Cross and Blue Shield.

14. In addition to the specific allegations of this complaint, Hartenstine has asserted that Blue Cross' retrospective review of claims for Pamela Hartenstine's hospitalization are per se badfaith.

15. The court finds that the provisions of 5 USC §8902(m)(l) apply to and preempt cross-complainant's second and third causes of action in their entirety. Specifically, the court finds that the retrospective review complaint of is a matter relating to the "nature and extent of coverage or benefits, including payments with respect to benefits" contemplated by the statute. Further, the court finds that the federal employees health benefits act so comprehensively provides for the nature and extent of coverage and for payment dispute resolution that application of the alleged state causes of action is inconsistent with the provisions of the act.

16. The court finds that the emotional distress tort relief in the first cause of action of Hartenstine's cross-complaint is, likewise, not provided for by the federal employees health benefits act and is preempted.

17. The court finds that punitive damages are neither provided for nor allowed under the federal employees health benefits act and are thus preempted.

Dated: 1-12-87

/s/ Leroy A. Simmons
Judge of the Superior Court

APPENDIX D

FEDERAL HEALTH BENEFITS ACT
TITLE 5, UNITED STATES CODE

§8901. Definitions

For the purpose of this chapter [5 USCS §§8901 et seq.] —

(1) "employee" means —

(A) an employee as defined by section 2105 of this title [USCS §2105];

(B) a Member of Congress as defined by section 2106 of this title [5 USCS §2106];

(C) a Congressional employee as defined by section 2107 of this title [5 USCS §2107];

(D) the President;

(E) an individual first employed by the government of the District of Columbia before October 1, 1987;

(F) an individual employed by Gallaudet College; and

(G) an individual employed by a county committee established under section 590h(b) of title 16 [16 USCS §590h(b)];

but does not include —

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter [5 USCS §§8901 et seq.] on September 30, 1979, by reason of service in an Executive agency, the United States Postal

Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Manaement under section 8913(b) of this title [5 USCS §8913(b)];

2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means —

(A) an employee who retires —

(i) on an immediate annuity under subchapter III of chapter 83 of this title [5 USCS §§8331 et seq.], or another retirement system for employees of the Government, after 5 or more years of service;

(ii) under section 8412 or 8414 of this title [5 USCS §8412 or 8414]; or

(iii) for disability under subchapter III of chapter 83 of this title, chapter 84 of this title [5 USCS §§8331 et seq., 8401 et seq.], or another retirement system for employees of the Government;

(B) a member of a family who receives an immediate annuity as the survivor of an employee (including a family member entitled to an amount under section 8442(b)(1)(A) [5 USCS §8442(b)(1)(A)], whether or not such family member is entitled to an annuity under section 8442(b)(1(B) [5 USCS §8442(b)(1)(B)]) or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title [5 USCS §§8101 et seq.] and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title [5 USCS§§8101 et seq.] as the surviving beneficiary of —

(i) an employee dies as a result of injury or illness compensable under that subchapter [5 USCS §§8101 et seq.]; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter [5 USCS §§8101 et seq.] and who has been held by the Secretary to have been unable to return to duty;

(4) "service," as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 or chapter 84 of this title [5 USCS §§8331 et seq., 8401 et seq.];

(5) "member of family" means the spouse of an empoyee or annuitant an unmarried dependent child under 22 years of age, including —

(A) an adopted child or recognized natural child; and

(B) stepchild or foster child but only if the child; lives with the employee or annuitant in a regular parent-child relationship;

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization;

(8) "employee organization" means —

(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter [5 USCS §§8901 et seq.] and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title [5 USCS §8903[3]; and

(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title [enacted June 17, 1985], applied to the Office for approval of a plan provided under such section [5 USCS §8903a];

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe;

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant —

(A) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter [5 USCS §§8901 et seq.] as a family member at any time during the 18-month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C)(i) who is receiving any portion of an annuity under section 8345(j) or 8467 of this title [5 USCS §8345(j) or 8467] or a survivor annuity under section 8341(h) or 8445 of this title [5 USCS §8341(h) or 8445] (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System or the Federal Employees' Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h)[,] 8345(j), 8445, or 8467 of this title [5 USCS §8341(h), 8345(j), 8445, or 8467] (or similar provision of law under any such retirement system other than the Civil Service Retirement System or the Federal Employees' Retirement System) has been issued, or for whom an election has been made under section

8339(j)(3) or 8417(b) of this title [5 USCS §8339(j)(3) or 8417(b)] (or similar provision of law), or

(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former employee's separation from the service (other than by retirement); and

(11) "qualified clinical social worker" means an individual —

(A) who is licensed or certified as a clinical social worker by the State in which such individual practices; or

(B) who, if such State does not provide for the licensing or certification of clinical social workers —

(i) is certified by a national professional organization offering certification of clinical social workers; or

(ii) meets equivalent requirements (as prescribed by the Office).

§8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title [5 USCS §§8903, 8903a], without regard to section 5 of title 41 [41 USCS §5] or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made

automatically renewable from term to term in the absence of notice of termination by either party.

(b) to be eligible as a carrier for the plan described by section 8903(2) of this title [5 USCS §8903(2)], a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title [5 USCS §8903(1) or (2)] shall require the carrier —

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the Unites Stataes during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter [5 USCS §§8901 et seq.] shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title [5 USCS §§8903, 8903a] and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 [5 USCS §§551 et seq.] and chapter 7 of this title [5 USCS §§701 et seq.]. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the

preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, or former spouse whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, or former spouse who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title [5 USCS §§8903, 8903a] shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title [5 USCS §8903(1), (2)] shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustments in rates shall be made in advance of the contract term in

which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, or former spouse is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter [5 USCS §§8901 et seq.] requires payment or reimbursement for services which may be performed by a clinical psychologist or optometrist, licensed or certified as such under Federal or State law, as applicable, an employee, annuitant, family member, or former spouse covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist or optometrist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) When a contract under this chapter [5 USCS §§8901 et seq.] requires payment or reimbursement for services which may be performed by a qualified clinical social worker, an employee, annuitant, family member, or former spouse covered by the contract shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. As a condition for the payment or reimbursement, the contract —

(A) may require that the services be performed pursuant to a referral by a psychiatrist; but

(B) may not require that the services be performed under the supervision of a psychiatrist or other health practitioner.

(3) The provisions of this subsection shall not apply to group practice prepayment plans.

(l) The Office shall contract under this chapter for a plan described in section 8903(4) of this title [5 USCS §8903(4)] with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection,"qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d))

(m)(1) The provisions of any contract under this chapter [5 USCS §§8901 et seq.] which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter [5 USCS §§8901 et seq.] provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated

pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e) [42 USCS §254e]. This paragraph shall apply with respect to a qualified clinical social worker covered by subsection (k)(2) of this section without regard to whether such contract contains the requirement authorized by clause (i) of the second sentence of subparagraph (A) of such subsection (k)(2).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title [5 USCS §8903(4)].

§8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service Benefit Plan. One Government-wide plan, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title [5 USCS §8904(1)], given to employees, annuitants, members of their families, or former spouses, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, or former spouse.

(2) Indemnity Benefit Plan.— One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title [5 USCS §8904(2)].

(3) Employee Organization plans. — Employee organization plans which offer benefits of the types referred to

by section 8904(3) of this title [5 USCS §8904(3)], which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations described in section 8901(8)(A) of this title [5 USCS §8901(8)(A)], which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) Comprehensive Medical Plans. —

(A) Group-practice prepayment plans. — Group-practice prepayment plans which offer health benefits of the types referred to by section 8904(4) of this title [5 USCS §8904(4)], in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include at least 3 physicians who receive all or a substantial part of their professional income from the prepaid funds and who represent 1 or more medical specialties appropriate and necessary for the population proposed to be served by the plan.

(B) Individual-practice prepayment plans. — Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions apprvoed by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

(C) Mixed model prepayment plans. Mixed model prepayment plans which are a combination of the type of plans described in subparagraph (A) and the type of plans described in subparagraph (B).

§8903a. Additional health benefits plans

(a) In addition to any plan under section 8903 of this title [5 USCS §8903], the Office of Personnel Management may contract for or approve one or more health benefits plans under this section.

(b) A plan under this section may not be contracted for or approved unless it —

(1) is sponsored or underwritten, and administered, in whole or substantial part, by an employee organization described in section 8901(8)(B) of this title [5 USCS §8901(8)(B)];

(2) offers benefits of the types named by paragraph (1) or (2) of section 8904 of this title or both [5 USCS §8904(1), (2)];

(3) provides for benefits only by paying for, or providing reimbursement for, the cost of such benefits (as provided for under paragraph (1) or (2) of section 8903 of this title [5 USCS §8903(1), (2)] or a combination thereof; and

(4) is available only to individuals who, at the time of enrollment, are full members of the organization and to members of their families.

(c) A contract for a plan approved under this section shall require the carrier —

(1) to enter into an agreement approved by the Office with an underwriting subcontractor licensed to issue group health insurance in all the States and the District of Columbia; or

(2) to demonstrate ability to meet reasonable minimum financial standards prescribed by the Office.

(d) For the purpose of this section, an individual shall be considered a full member of an organization if such individual is eligible to exercise all rights and privileges incident to full membership in such organization (determined without regard to the right to hold elected office).

§8904. Types of benefits

The benefits to be provided under plans described by section 8903 of this title [5 USCS §8903] may be of the following types:

(1) Service Benefit Plan.—

(A) Hospital benefits.

(B) Surgical benefits.

(C) In-hospital medical benefits.

(D) Ambulatory patient benefits.

(E) Supplemental benefits.

(F) Obstetrical benefits.

(2) Indemnity Benefit Plan.—

(A) Hospital care.

(B) Surgical care and treatment.

(C) Medical care and treatment.

(D) Obstetrical benefits.

(E) Prescribe drugs, medicines, and prosthetic devices.

(F) Other medical supplies and services.

(3) Employee Organization plans. — Benefits of the types named under paragraph (1) or (2) of this section or both.

(4) Comprehensive Medical Plans. — Benefits of the types named under paragraph (1) or (2) of this section or both.

All plans contracted for under paragraphs (1) and (2) of this section shall include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature.

§8905. Election of coverage

(a) An employee may enroll in an approved health benefits plan described by section 8903 or 8903a of this title [5 USCS §§8903, 8903a] either as an individual or for self and family.

(b) An annuitant who at the time he becomes an annuitant was enrolled in a health benefits plan under this chapter [5 USCS §§8901 et seq.] —

(1) as an employee for a period of not less than —

(A) the 5 years of service immediately before retirement;

(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the date on which he becomes an annuitant; or

(C) the full period or periods of service beginning with the enrollment which became effective before January 1, 1965, and ending with the date on which he becomes an annuitant;

whichever is shortest; or

(2) as a member of the family of an employee or annuitant;

may continue his enrollment under the conditions of eligibility prescribed by regulations of the Office. The

Office may, in its sole discretion, waive the requirements of this subsection in the case of an individual who fails to satisfy such requirements if the Office determines that, due to exceptional circumstances, it would be against equity and good conscience not to allow such individual to be enrolled as an annuitant in a health benefits plan under this subchapter.

(c)(1)

A former spouse may —

(A) within 60 days after the dissolution of the marriage, or

(B) in the case of a former spouse of a former employee whose marriage was dissolved after the employee's retirement, within 60 days after the dissolution of the marriage or, if later, within 60 days after an election is made under section 8339(j)(3) or 8417(b) of this title [5 USCS §8339(j)(3) or 8417(b)] for such former spouse by the retired employee,

enroll in an approved health benefits plan described by section 8903 or 8903a of this title [5 USCS §§8903, 8903a] as an individual or for self and family as provided in paragraph (2) of this subsection, subject to agreement to pay the full subscription charge of the enrollment, including the amounts determined by the Office to be necessary for administration and reserves pursuant to section 8909(b) of this title [5 USCS §8909(b)]. The former spouse shall submit an enrollment application and make premium payments to the agency which, at the time of divorce or annulment, employed the employee to whom the former spouse was married or, in the case of a former spouse who is receiving annuity payments under section 8341(h)[,] 8345(j), 8445,

or 8467 of this title [5 USCS §8341(h), 8345(j), 8445, or 8467], to the Office of Personnel Management.

(2) Coverage for self and family under this subsection shall be limited to —

(A) the former spouse; and

(B) unmarried dependent natural or adopted children of the former spouse and the employee who are —

(i) under 22 years of age; or

(ii) incapable of self-support because of mental or physical disability which existed before age 22.

(d) If an employee has a spouse who is an employee, either spouse, but not both, may enroll for self and family, or each spouse may enroll as an individual. However, an individual may not be enrolled both as an employee or annuitant and as a member of the family.

(e) An employee, annuitant, or former spouse enrolled in a health benefits plan under this chapter [15 USCS §§8901 et seq.] may change his coverage or that of himself and members of his family by an application filed within 60 days after a change in family status or at other times and under conditions prescribed by regulations of the Office.

(f)(1) Under regulations prescribed by the Office, the Office shall, before the start of any contract term in which —

(A) an adjustment is made in any of the rates charged or benefits provided under a health benefits plan described by section 8903 or 8903a of this title [5 USCS §8903 or 8903a],

(B) a newly approved health benefits plan is offered, or

(C) an existing plan is terminated,

provide a period of not less than 3 weeks during which any employee, annuitant, or former spouse enrolled in a health benefits plan described by such section shall be permitted to transfer that individual's enrollment to another such plan or to cancel such enrollment.

(2) In addition to any opportunity afforded under paragraph (1) of this subsection, an employee, annuitant, or former spouse enrolled in a health benefits plan under this chapter [5 USCS §§8901 et seq.] shall be permitted to transfer that individual's enrollment to another such plan, or to cancel such enrollment, at such other times and subject to such conditions as the Office may prescribe in regulations.

§8906. Contributions

(a) The Office of Personnel Management shall determine the average of the subscription charges in effect on the beginning date of each contract year with respect to self alone or self and family enrollments under this chapter [5 USCS §§8901 et seq.], as applicable, for the highest level of benefits offered by —

(1) the service benefit plan;

(2) the indemnity benefit plan;

(3) the two employee organization plans with the largest number of enrollments, as determined by the Office; and

(4) the two comprehensive medical plans with the largest number of enrollments, as determined by the Office.

(b)(1) Except as provided by paragraphs (2) and (3) of this subsection, the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter [5 USCS §§8901

et seq.] is adjusted to an amount equal to 60 percent of the average subscription charge determined under subsection (a) of this section. For an employee, the adjustment begins on the fist day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title [5 USCS §3401(2)]) the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office)[.]

(c) There shall be withheld from the pay of each enrolled employee and the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this seciton, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title [5 USCS §8909(b)].

(d) The amount necessary to pay the total charge for enrollment, after the Government contribution is deducted,

shall be withheld from the pay of each enrolled employee and from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e)(1) An empoyee enrolled in a health benefits plan under this chapter [5 USCS §§8901 et seq.] who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office. The regulations may provide for the waiving of contributions by the employee and the Government.

(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title [5 USCS §8901], within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently in to the Employees Health benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by paragraph (1) of this subsection and implementing regulations.

(f) The Government contributions for health benefits for an employee shall be paid —

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Clerk of the House of Representatives, from the contingent fund of the House; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g)(1) Except as provided in paragraph (2), the Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(2) The Government contributions authorized by this section for health benefits for an individual who first becomes an annuitant by reason of retirement from employment with the United States Postal Service on or after October 1, 1986, shall be paid by the United States Postal Service.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

§8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter [5 USCS §§8901 et seq.] such information, in a form acceptable to the Office after

consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by sections 8903 and 8903a of this title [5 USCS §§8903, 8903a].

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the —

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

§8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title [5 USCS §8096] shall be paid into the Fund. The Fund is available —

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter [5 USCS §§8901 et seq.] within the limitations that may be specified annually by Congress.

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably

adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the office to be reasonably adequate to provide a contingency reserve.

The Office from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title [5 USCS §§8903(3), 8903a] are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be

transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organizaiton. Each employee, annuitant, or former spouse affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter [5 USCS §§8901 et seq.]. If the successor organization is an organization described in section 8901(8)(B) of this title [5 USCS §8901(8)(B)], any employee, annuitant, or former spouse so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title [5 USCS §8903a(d)]).

(e) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title [5 USCS §§8903(3) or (4), 8903a] is discontinued under this chapter [5 USCS §§8901 et seq.], the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter [5 USCS §§8901 et seq.] for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

§8910. Studies, reports, and audits

(a) The Office of Personnel Management shall make a continuing study of the operation and administration of this chapter [5 USCS §§8901 et seq.], including surveys and reports on health benefits plans available to employees and on the experience of the plans.

(b) Each contract entered into under section 8902 of this title [5 USCS §8902] shall contain provisions requiring carriers to —

(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter [5 USCS §§8901 et seq.]; and

(2) permit the Office and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this chapter [5 USCS §§8901 et seq.]

(c) Each Government agency shall keep such records, make such certifications, and furnish the Office with such information and reports as may be necessary to enable the Office to carry out its functions under this chapter [5 USCS §§8901 et seq.].

§8911. Advisory committee

The Director of the Office of Personnel Management shall apppoint a committee composed of five members, who serve without pay, to advise the Office regarding matters of concern to employees under this chapter [5 USCS §§8901 et seq.]. Each member of the committee shall be an employee enrolled under this chapter [5 USCS §§8901 et seq.] or an elected official of an employee organization.

§8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court, of a civil action or claim against the United States founded on this chapter [5 USCS §§8901 et seq.].

§8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter [5 USCS §§8901 et seq.].

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described by section 8903 or 8903a of this title [5 USCS §§8903, 8903a]. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermitten employment, and employment of like nature. The Office may not exclude —

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary apppointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years; or

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3402(2) of this title [5 USCS §3401(2)]).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title [5 USCS §8902(g)], until the end of the pay period in which an employee is separated from the service, or until the end of

the month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter [5 USCS §§8901 et seq.] to an indivdual named by section 8902(1)(H) of this title [5 USCS §8901(1)(H)].

APPENDIX E

CALIFORNIA INSURANCE CODE

ARTICLE 6.5 Unfair Practices

§790. Purpose

The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, Seventy-ninth Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

§790.01. Application

This article applies to reciprocal and interinsurance exchanges, Lloyds insurers, fraternal benefit societies, fraternal fire insurers, grants and annuities societies, insurers holding certificates of exemptions, motor clubs, nonprofit hospital associations, agents, brokers, solicitors, surplus line brokers and special lines surplus line brokers as well as all other persons engaged in the business of insurance.

§790.02. Unfair practices in business of insurance prohibited

No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to this article to be, an unfair method of competion or an unfair or deceptive act or practice in the business of insurance.

§790.03. Prohibited unfair or deceptive acts or practices

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(b) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive or misleading.

(c) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion

or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public offical to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(f) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if such differentials are substantially supported by valid pertinent data segregated by sex, including, but not necessarily limited to, mortality data segregated by sex.

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of such differentials based on data segregated by sex, rates or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. 'Compliance date' as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.5 and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as such terms are used in Title VII of the Civil Rights Act of 1964, as amended, and (2) tax sheltered annuities for employees of public schools or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any

newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063) of this chapter.

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, when such insureds have

made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

§790.04. Investigation by commissioner

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in the State in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 790.03 or determined pursuant to this article to be an unfair method of competition or an unfair or deceptive practice in the business of insurance. Such investigation may be conducted pursuant to Article 2 (commencing at Section 11180) of Chapter 2, Part 1, Division 3, Title 2 of the Government Code.

§790.05. Procedure

Whenever the commissioner shall have reason to believe that any such person has been engaged or is engaging in this State in any unfair method of competition or any unfair or deceptive act or practice defined in Section 790.03, and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and serve upon such person an order to show cause containing a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to such person to cease and desist such methods, acts or practices or any of them.

If the charges or any of them ae found to be justified the commissioner shall issue and cause to be served upon such person an order requiring such person to cease and desist from engaging in such methods, acts, or practices as have been found to be unfair or deceptive.

Such hearing shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing at Section 11500) of Part 1, Division 3, Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

Such person shall be entitled to have such proceedings and such order reviewed by means of any remedy provided by Section 12940 of this code or by said Administrative Procedure Act.

§790.06. Procedure: Conduct not specified in statute

(a) Whenever the commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this State in any method of competition or in any act or practice in the conduct of such business which is not defined in Section 790.03 and that such method is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be in the interest of the public, he may issue and serve upon such person an order to show cause containing a statement of the methods, acts or practices alleged to be unfair or deceptive and notice of hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the alleged methods, acts or practices or any of them should be declared to be unfair or deceptive within the meaning of this article.

The hearing provided by this section shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing at Section 1500) of Part 1, Division 3, Title 2 of the Government Code, and the commissioner shall have all the powers granted therein. If the alleged methods, acts, or practices or any of them are found to be unfair or deceptive within the meaning of this article the commissioner shall issue and service upon said person his written report so declaring.

(b) If such report charges a violation of this article and if such method of competition, act or practice has not been discontinued, the commissioner may, through the Attorney General of this State, at any time after 30 days after the service of such report cause a petition to be filed in the superior court of this State within the county wherein the person resides or has his principal place of business, to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(c) A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings shall be filed with such petition. If either party shall apply to the court for leave to adduce additional evidence and shall show, to the satisfaction of the court, that such additional evidence is material and there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his

findings of fact or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings with the return of such additional evidence.

(d) If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair or deceptive, that the proceeding by the commissioner with respect thereto is to the interest of the public and that the findings of the commissioner are supported by the weight of the evidence, it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

§790.07. Penalty for violation of orders

Whenever the commissioner shall have reason to believe that any person has violated a cease and desist order issued pursuant to Section 790.05 or a court order issued pursuant to Section 790.06, after the order has become final, and while the order is still in effect, the commissioner may, after a hearing at which it is determined that the violation was committed, order that person to forfeit and pay to the State of California a sum not to exceed five thousand dollars ($5,000), which may be recovered in a civil action, except that, if the violation is found to be willful, the amount of the penalty may be a sum not to exceed fifty-five thousand dollars ($55,000).

For any subsequent violation of the cease and desist order or of the court order, while any such order is still in effect, the commissioner may, after hearing, suspend or revoke the license or certificate of that person for a period not exceeding one year; provided, however, no such proceeding shall be based upon the subsequent violation unless the same was committed or continued after the date on which the order imposing the penalty pursuant to the preceding paragraph became final.

The hearings provided by this section shall be conducted in accordance with the Administrative Procedure Act, and the commissioner shall have all the powers granted therein.

The person shall be entitled to have the proceedings and the order of the commissioner therein reviewed by means of any remedy provided by Section 12940 of this code or by said Administrative Procedure Act.

§790.08. Powers vested in commissioner

The powers vested in the commissioner in this article shall be additional to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

§790.09. Civil and criminal liability uneffected

No order to cease and desist issued under this article directed to any person or subsequent administrative or judicial proceeding to enforce the same shall in any way relieve or absolve such person from any administrative action against the license or certificaate of such person, civil liability or criminal penalty under the laws of this State arising out of the methods, acts or practices found unfair or deceptive.

§790.10. Rules and regulations

The commissioner shall, from time to time as conditions warrant, after notice and public hearing, promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article.